

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05692									
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY in 1b 22 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Devine Nurseing Home					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural d. STREET ADDRESS Aikin e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Florence M. Aikin					4. DATE OF DEATH Month May Day 20 Year 19 62				
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1881		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Lewis C. Ewing					14. MOTHER'S MAIDEN NAME Eliza Jane Montgomery				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-20-4728		17. INFORMANT Address Samuel Aikin Jr., Perryville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Acute cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis, generalized (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) several yr									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4-28-62 to 5/20/62 , that (I) (we) last saw the deceased alive on 5/17/62 , and that death occurred at 7:20a.m. from the causes and on the date stated above. 22a. SIGNATURE S. Ralph Andrews, Jr., M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE 5/21/62 22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. 22d. ADDRESS 23a. BURIAL, CREMATION, or other disposition (Specify) Burial 23b. DATE THEREOF 5-23-1962 23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery 23d. LOCATION (City, town or county) (State) Perryville, Md. Rural 24. FUNERAL DIRECTOR'S SIGNATURE Lee a. Patterson & Son, Perryville, Md ADDRESS Perryville, Md 25a. REC'D BY REGISTRAR MAY 23 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

(M)

1953

05803

W. Geall

Wetlands

Harbor

Portville, Alaska

having interest in home

Alaska

Flowers

Alaska

female white

July 7, 1951

house wife

own home

Alaska

Lewis C. Knight

Eliza Jane Montgomery

813-20-4728 Samuel Aikin Jr., Portville, Mo.

Acute cerebral hemorrhage

several yr.

Arteriosclerosis, generalized

unknown

2/17/02

4-18-02

5/20/02

7:20 a.m.

2/17/02

S. Ralph Andrews, Jr., M.D.

5-2-1954 Dr. Morris Comstock, Portville, Mo. Rural

Portville, Mo. 64852

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05698

05693

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN Ib 36 years		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
3. NAME OF DECEASED (Type or print) HARRY			4. DATE OF DEATH May 16 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-97	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 11 Days 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None		17. INFORMANT VA Hospital Records, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of Colon due to disturbance to circulation 570.3 DUE TO Volvulus of Sigmoid Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) " (c) " PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 18-24 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Aug 17, 25 May 16, 62	(County) (State)	
21. I certify that (this hospital) attended the deceased from 11:50 PM, 1962, and that death occurred at 11:50 PM, 1962, from the causes and on the date stated above.					
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED May 17, 1962		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. Asst. Pathologist	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/19/62		23c. NAME OF CEMETERY OR CREMATORY National Cemetery	
23d. LOCATION (City, town or county) Baltimore, Md.		23e. REC'D BY REGISTRAR DATE MAY 22 '62			
23f. REGISTRAR'S SIGNATURE Arthur S. Kraus		23g. REGISTRAR'S SIGNATURE			

(M)

05882

CENTRAL VA. OF HEALTH

05882

Cost

Baltimore

Baltimore

Point Point

30 years

Baltimore

VA Hospital

VA F. Preston St

HARRY

ARCHER

NOV

16

82

Wife

Wife

6-17-37

84

11

5

Laborer

Construction

Baltimore, Maryland

Unknown

Unknown

Yes

Yes

Home

VA Hospital, Baltimore, Point, Md.

VA Hospital, Baltimore, Point, Md.

11-14-1944

Volunteer of St. Joseph's

VA

Age 75

May 16

1962

11:50 PM

May 17, 1962

A. J. ROONEY, M.D.

Asst. Physician

National Cemetery

Baltimore, Md.

Removal

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05699

CERTIFICATE OF DEATH

05694

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 4 mo. 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last BOONE				4. DATE OF DEATH Month May Day 1 Year 1962			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-79	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 5 Days 7	IF UNDER 24 HRS. Hours 5 Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman Porter				10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME John E. Boone (deceased)				14. MOTHER'S MAIDEN NAME Ella Cooley (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes S.A.W.				16. SOCIAL SECURITY NO. 578-38-3954		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO (b) Adenocarcinoma of prostate with metastasis to the vertebra and pelvis DUE TO (c) to the vertebra and pelvis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 5-7 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour VA e.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXXXXXX attended the deceased from December 28, 1961 to May 1, 1962 and that death occurred at 11:40 pm M, from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-2-62	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 5/4/1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Bennington + Son, Hound Chase, Md.				25a. REC'D BY REGISTRAR MAY 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hane	

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00000

M

Cell

Perry Point

4 mo. 5 days

Washington

Veterans Administration Hospital

1907 - 2nd class, N.Y.

JOHN

BOON

May

62

Wife

Wife

10-1-73

62

William Porter

Wilmington, Co.

Virginia

USA

John E. Boone (deceased)

Ellie Goolley (deceased)

S.A.V.

278-38-5224 Hospital Reentry, Van, Perry Point, Md.

Yes

Stenochonchosis, bilateral, unresolvd

5-7 days

Abnormalities of processes with metastasis to the vertebra and pelvis

unknown

VA

XXXXXXXXXX

December 28, 61 May 1

11:40 pm

X

2-2-62

A. J. W. [unclear]

A. J. W. [unclear] Ass. Clinical Psychologist, VAN, Perry Point, Md.

Arlington, Virginia

Arlington National

5/1/62

James H. [unclear]

CERTIFICATE OF DEATH

Reg. Dist. No.

05700

05695

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b 67 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last BOYER				4. DATE OF DEATH Month May Day 9 Year 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1877		9. AGE (In years lost birthday) yrs. 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Clark				14. MOTHER'S MAIDEN NAME Hannah -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		INFORMANT Mrs Alice Weaver North East, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 16 years 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 15 June, 1946 , to 9 May, 1962 , that I last saw the deceased alive on 7 May, 1962 , and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner		M.D.		ADDRESS (Street, city or town, state) North East, Md		DATE SIGNED 5/9/62	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-12-1962	22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE MAY 11 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

X. BOMBARDIER-NTN-DO INSTRUMENTO DE AVALIAÇÃO

• **Stress** • **Stress** • **Stress**

1000

232

CERTIFICATE OF DEATH

Reg. Dist. No.

05701

05696

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1 107 Milburn Street			
3. NAME OF DECEASED (Type or print) First Florence Middle E. Last Brady				4. DATE OF DEATH Month May Day 9 Year 19 62			
5. SEX Fe	6. COLOR OR RACE Color	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/02	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Matthews				14. MOTHER'S MAIDEN NAME Sarah N. Ennals			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Melvin Brady-107 Milburn St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42011 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cardiac Failure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/8 1962 to 5/9 1962 that I last saw the deceased alive on 5/8 1962, and that death occurred at 11A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James L. Johnson		M.D. 245 E. High St. Elkton, Md.		DATE SIGNED 5/11/62			
PHYSICIAN'S NAME (Type) James L. Johnson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/62		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Bell		ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE MAY 15 62		24b. REGISTRAR'S SIGNATURE Robert A. ...	

1

Page 4

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10701

4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 ~~4~~ (M) 50 (I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05702 CERTIFICATE OF DEATH 05697

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN lb 4 mo. 9 days	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 1513 Lilac Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILTON THOMAS CLARK		4. DATE OF DEATH Month May Day 7 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-07
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore T. Clark		14. MOTHER'S MAIDEN NAME Mary Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. unknown	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's Cirrhosis 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXXXXXXXX attended the deceased from December 28 1961 to May 7 1962 and that death occurred at 12:15pm from the causes and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 5-7-62	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, Chief, Medical Service, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-62	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR MAY 10 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

02702

02702

STATEMENT OF DEATH

Name: Theodore J. Clark
 Sex: Male
 Race: White
 Date of Birth: 1-20-01
 Place of Birth: Maryland
 Occupation: Proprietor
 Cause of Death: Unknown
 Date of Death: 11-11-61
 Place of Death: Hospital, Vets. Affairs, Md.
 Informant: Mary Taylor
 Address: 1215 Allen Drive, Salisbury, Md.
 Telephone: 252-1111

Date of Death: December 28, 1961
 Time of Death: 12:15pm
 Informant: E. J. JORDAN, Chief, Medical Service, Vets. Affairs, Md.
 Address: 1215 Allen Drive, Salisbury, Md.
 Telephone: 252-1111

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05703

05698

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Md. c. LENGTH OF STAY in 1b 7yrs. 7mo. 7days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington g. STREET ADDRESS 100 G. Street, N.W. h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIS A. CORNWELL		4. DATE OF DEATH Month May Day 22 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-89
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4	11. IF UNDER 24 HRS. Hours 10 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John G. Cornwell (deceased)		14. MOTHER'S MAIDEN NAME Mary Page (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW-I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarctions of lungs due to emboli 463X Conditions, if any, which gave rise to immediate cause (b) Thrombophlebitis, lower extremities (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3-4 days		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. VA 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from October 15, 1954 to May 22, 1962 and that death occurred at 4:10 p.m. from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 5-23-62	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 5/25/1962	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR MAY 31 1962	
25b. REGISTRAR'S SIGNATURE Arthur S. Kimes			

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Forty Point, VA.

Forty Point, VA.

Washington

Veteran Administration Hospital

100 G. Street, N.W.

WILLIS

CORNWELL

May

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Male

White

7-24-89

72

Former

Farmer

Virginia

USA

John G. Cornwell (deceased) Mary Page (deceased)

See U-1 home hospital records, VA, Forty Point, VA.

Information of interest to exobiology

Thrombophilic, lower extremities

VA

October 15 54 May 42

4:10 p.m.

XXXXXXXXXXXXXXXXXXXX

G. J. Kitchener

A. E. MOORE, Asst. Clinical Pathologist, VA, Forty Point, VA.

Arlington National, Arlington, Va.

Reopened, grave de Green, VA.

TO HOSPITAL
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.
VR A15 (4)
15M 9/60

THE law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05704											
05699											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 149 North Main St.						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 149 North Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Roland Creswell						4. DATE OF DEATH May 5 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1899		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 5 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer						10b. KIND OF BUSINESS OR INDUSTRY U.S. Ordn. Dept.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Creswell						14. MOTHER'S MAIDEN NAME Georgia Anna Morrison					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. (If assigned war or defense service) 215-07-3665		17. INFORMANT Elizabeth F. Creswell, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ANGINA PECTORIS (c) GENERALIZED SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 30 MIN. 5 yrs. 10 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June 1 , 19 62 to 5-5 , 19 62 that (I) (we) last saw the deceased alive on 5-4 , 19 62 and that death occurred at 2 M, from the causes and on the date stated above.											
22a. SIGNATURE G.H. Richards, Jr.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS Port Deposit, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 5-8-1962											
23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery											
23d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural											
24. FUNERAL DIRECTOR'S SIGNATURE Lea, Patterson & Son, Perryville, Md.											
25a. REC'D BY REGISTRAR MAY 8 '62											
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G313 5/25/62 mh

CERTIFICATE OF DEATH

05705

05700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE INDIANA b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-COLORA				c. LENGTH OF STAY IN 1b 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KOKOMO 52X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				d. STREET ADDRESS 144 S. BURKLEY RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHY First Middle Last A. DEMPSEY				4. DATE OF DEATH Month MAY Day 17 Year 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 16, 1916		9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) COLORA, MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARRY DINSMORE				14. MOTHER'S MAIDEN NAME MARY JANE KRAUSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		INFORMANT Address WILLIAM DEMPSEY KOKOMO, IND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Pulmonary congestion (edema) 3 days DUE TO (b) bronchogenic carcinoma 9 months DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/17/62 to 5/17/62 , that I last saw the deceased alive on 5/17/62 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 5/17/62 ACTUAL SIGNATURE Neil Taylor M.D. Rising Sun, Md. 5/17/62 PHYSICIAN'S NAME (Type) Neil Taylor Rising Sun, Md. 5/17/62							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/20/1962		22c. NAME OF CEMETERY OR CREMATORY BROOKVIEW CEMETARY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph M Reed Rising Sun, Md.				24a. REC'D BY REGISTRAR DATE MAY 21 '62		24b. REGISTRAR'S SIGNATURE Charles S. Krauss	

TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS

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(M)

IN SENATE,
January 10, 1900.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1899.
BY
J. W. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS
PRINTING CO., 1899.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician. The law requires that the death certificate be executed within hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
05706					05701									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Cecil			e. STATE		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Perry Point			b. COUNTY		Harford							
c. LENGTH OF STAY IN		25 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Magnolia							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		VA Hospital			d. STREET ADDRESS		-							
e. IS RESIDENCE ON A FARM?					e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED			First			Middle			Last					
(Type or print)			Edward			P.			Dwaayer					
5. SEX			6. COLOR OR RACE			7. MARRIED			8. DATE OF BIRTH					
Male			White			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			12-8-94					
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									67 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Foreman			U.S. Govt.,			Magnolia, Maryland			U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
John C. Dwaayer					Sarah Turner									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
Yes					WW I					220-20-7402				
										VA Hospital Records - Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, unresolved, severe</u>										7-9 days				
527.1 DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>pulmonary emphysema</u>				
										(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
Osteo-arthritis														
19. WAS AUTOPSY PERFORMED?														
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
2Dc. TIME OF INJURY Month, Day, Year														
Hour e.m. p.m. 19														
20d. INJURY OCCURRED														
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>														
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)														
20f. (City or town) (County) (State)														
21. I certify that (this hospital) attended the deceased from April 18, 1962, to May 12, 1962, and that death occurred at 11:30 P.M. from the causes and on the date stated above.														
22a. SIGNATURE														
A. L. MOONEY, M.D.														
22b. DATE														
May 13, 1962														
22c. PHYSICIAN'S NAME (Type)														
Asst. Pathologist														
22d. ADDRESS														
Perry Point, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify)														
Removal														
23b. DATE THEREOF														
5 16 62														
23c. NAME OF CEMETERY OR CREMATORY														
Memorial Gardens														
23d. LOCATION (City, town or county) (State)														
Bel Air, Maryland														
24 FUNERAL DIRECTOR'S SIGNATURE														
HOWARD MC COMAS FUNERAL HOME-Abingdon, Md.														
25a. REC'D BY REGISTRAR														
DATE 5 13 62 '62														
25b. REGISTRAR'S SIGNATURE														
Arthur L. Hume														

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1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

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CERTIFICATE OF DEATH

05702

Reg. Dist. No.

05707

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elkton Memorial Hospital				d. STREET ADDRESS 126 E. Cleveland Ave.			
3. NAME OF DECEASED (Type or print) First Tolliver Middle C. Last Gamble				4. DATE OF DEATH Month May Day 31 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1900		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Fibre		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Monroe Gamble				14. MOTHER'S MAIDEN NAME Hannah Moxley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 186-07-1983		INFORMANT Winnie M. Gamble		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 195.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis DUE TO (c) Midulary Carcinoma of Adrenal & wide spread 2 months						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31, 19 62 to May 31, 19 62 that I last saw the deceased alive on May 31, 19 62 and that death occurred at 6:58 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 205 West Main St. DATE SIGNED 5-1-62							
ACTUAL SIGNATURE Joseph G. Ianzi M.D.				205 West Main St.			
PHYSICIAN'S NAME (Type) Joseph G. Ianzi, M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-3-62		22c. NAME OF CEMETERY OR CREMATORY New London Presby. Cem.		22d. LOCATION (City, town, or county) (State) New London, Penna	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Warwick				ADDRESS Newark, Delaware		24a. REC'D BY REGISTRAR DATE JUN 6 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

WILLIAM J. WARWICK

Page 4

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1907

CERTIFICATE OF DEATH

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State of New York
County of New York
City of New York
I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that on the _____ day of _____, 1907, at _____, New York, the body of _____, a _____ of _____ years of age, was found _____, and that the cause of death was _____, and that the death was due to _____, and that the death was not due to any other cause.

Witness my hand and the seal of the City and County of New York, this _____ day of _____, 1907.

Medical Officer of Health for the City and County of New York

Notary Public for the City and County of New York

Physician

Attorney at Law

WILLIAM WARWICK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05708

CERTIFICATE OF DEATH

05703

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. (D. C.) b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 1630-2	
e. STREET ADDRESS 6600 H. Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID R. GORMAN		4. DATE OF DEATH Month Day Year May 20 19 62	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep.		8. DATE OF BIRTH 3-12-16	
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cecil Gorman		14. MOTHER'S MAIDEN NAME Ella Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 Peritonitis diffuse due to extravasated contents of viscera (b) Adenocarcinoma of sigmoid with ulceration and fistulous tract (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that XXXXXXXXXX attended the deceased from April 30, 1962, to May 20, 1962, and that death occurred at 2:15pm from the causes and on the date stated above. 22e. SIGNATURE A. L. MOONEY M.D. 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. 22d. ADDRESS 22f. DATE SIGNED 5-21-62 22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/13/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR DATE MAY 28 '62	
25b. REGISTRAR'S SIGNATURE S. Kline			

Washington, D.C., June 10, 1962

John F. Kennedy, President

A. L. MOORE, Jr., M.D., Director, National Institute of Mental Health

Washington, D.C.

5-22-62

2:15pm

April 30, 1962

May 20

62XXXXXX

VA

and lithium treatment

management of alcohol with lithium

control of violence

Psychiatric illness due to extraneous

4-6 days

Yes

W-11

University

Hospital records, Van, Perry Point, Md.

Geoff Gordon

Ellen Williams

Assistant

Hospital

Maryland

USA

Male, Negro

1929

3-12-10

10

DAVID

E.

GORDON

Ray

62

Veterans Administration Hospital

6600 E. Street, N.E.

Left, 1961, 1962

30 days

Washington

Geoff

B. C.

25708

CENTRAL DE MEXICO

BOYD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05709 05704											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital						d. STREET ADDRESS Biddle St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE W. GORMAN						4. DATE OF DEATH Month Day Year May 10, 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1880		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper -				10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (County & State, or foreign country) Chestertown, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Gorman						14. MOTHER'S MAIDEN NAME Sarah Allen					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 218-32-2385		17. INFORMANT James W. Gorman Sr., Chesapeake City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auto + chronic myocardial 431X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Cardiac decompensation DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from May 10, 1962, to May 10, 1962, that (I) (we) last saw the deceased alive on May 10, 1962, and that death occurred at 2 P.M., from the causes and on the date stated above.											
22a. SIGNATURE Henry V. Davis M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED May 10, 1962		
22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD						22d. ADDRESS CHESAPEAKE CITY MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 13, 1962		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION (City, town or county) (State) Chesapeake City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME						ADDRESS Donnell Dr Elkton,			25a. REC'D BY REGISTRAR MAY 14 '62		
									25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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Reg. Dist. No.

05710

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 515 North Street				d. STREET ADDRESS 515 North Street			
3. NAME OF DECEASED (Type or print) CHARLES		First A. GRANT		Last GRANT		4. DATE OF DEATH Month May Day 30 Year 1962	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1895	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service station attendant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clark S. Grant				14. MOTHER'S MAIDEN NAME Mary Adelaide Work			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 212-01-2159		INFORMANT Mrs Anna Davis Grant		Address Elkton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Acute coronary occlusion Arteriosclerotic coronary artery disease several yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH none					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 8 , 19 60 , to May 30 , 19 62 that I last saw the deceased alive on May 29 , 19 62 , and that death occurred at 6:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland DATE SIGNED 5/30/62 ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-1962		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton City, MD Cecil, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant Joseph R. Grant		ADDRESS North East, Maryland		24a. RECEIVED BY REGISTRAR JUN 5 1962		24b. REGISTRAR'S SIGNATURE C. R. S. Travis	

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2701 2 22-11

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

05711

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05706

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BAINBRIDGE c. LENGTH OF STAY IN 1b 1 HOUR d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) STATION HOSPITAL USNTC BAINBRIDGE, MD				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MD. b. COUNTY CECIL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BAINBRIDGE CONOWINGO d. STREET ADDRESS CONOWINGO e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES A. HAYDEN JR.			4. DATE OF DEATH Month 5 Day 9 Year 62				
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-26	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months 35 Days 0 Hours 0 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NAVY		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) KY.			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME HAYDEN, JAMES A.				
14. MOTHER'S MAIDEN NAME HALL, LULA MAY			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW2				
16. SOCIAL SECURITY NO. 405-22-9387			17. INFORMANT Address MRS. JAMES A. HAYDEN JR. CONOWINGO, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease, severe (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 2 HRS. Unknown		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. DODSON MD			DATE SIGNED 5-9-62				
EXAMINER'S NAME (Type) R.C. Dodson MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) RISE SUN, MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-14-1962	22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.	22d. LOCATION (City, town, or country) Colora, Md.	(State)			
23. FUNERAL DIRECTOR Leea. Patterson & Son, Perryville, Md.			24a. REC'D BY REGISTRAR DATE MAY 14 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

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00100

(M)

10-10-30

U.S. NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 Maryland State Department of Health

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05712 CERTIFICATE OF DEATH 05707

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Virginia b. COUNTY Grayson	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Independence 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY E. HICKS		4. DATE OF DEATH Month May Day 29 Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-21
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Grayson County, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy C. Hicks		14. MOTHER'S MAIDEN NAME Linny Hackler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (Possibly related to Renal Condition) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Polycystic Kidneys and Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 5-22- 19 62 to 5-29- 19 62 , that (b) (one) last XXXXXX and that death occurred at 5:30PM from the causes and on the date stated above.		22a. SIGNATURE Bernard S. Linn M.D.	
22b. DATE SIGNED 5/30/62		22c. PHYSICIAN'S NAME (Type) BERNARD S. LINN, M.D.	
22d. ADDRESS VAH, Perry Point, Maryland		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-1-62	
23c. NAME OF CEMETERY OR CREMATORY Hackler Cemetery		23d. LOCATION (City, town or county) (State) Independence, Va. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE JUN 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur E. Huns			

05712

M

Local

Virginia

Virginia

Perry Point, Maryland

Local - Independence

Pepper's Independent Hospital

HEAVY

HEAVY

HEAVY

WHITE

4-11-21

4

Constitution

Constitution

Virginia County, Virginia

USA

Only 1. Alaska

Lincoln Backer

Yes

21-11

Unknown

Hospital records, VAB, Perry Point, Md.

Cerebral Vascular Accident

2 hours

Hypertension (Possibly related to renal condition)

Polycystic Kidneys and Uterus

2-22-62

2:30 PM

XXXXXXXXXXXXXXXXXXXX

2:30 PM

REINHARD E. LINN, M.D.

VAB, Perry Point, Maryland

2-22-62

Backer Cemetery

Independence, Va. Rural

05713

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05708

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NOAH</u> <u>JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>5</u> <u>22</u> <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1907</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland Materials</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca McCoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>235-05-4238</u>		17. INFORMANT Address <u>Mrs Betty Sloan Johnson, North East, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Rising Sun Md</u> <u>5-22-1962</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East, Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 28 '62</u>		24b. REGISTRAR'S SIGNATURE <u>James S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. It should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

HAWAIIAN STATE DEPARTMENT OF HEALTH - BATHING 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX _____	
3. AGE _____		4. RACE _____	
5. DATE OF DEATH _____		6. TIME OF DEATH _____	
7. PLACE OF DEATH _____		8. OCCASION OF DEATH _____	
9. CAUSE OF DEATH _____			
10. MANNER OF DEATH _____			
11. SIGNATURE OF MEDICAL EXAMINER _____			
12. SIGNATURE OF WITNESS _____			
13. SIGNATURE OF REGISTRAR _____			

05714

CERTIFICATE OF DEATH

Reg. Dist. No.

05709

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Newton Middle Heston Last Mahoney Sr.		4. DATE OF DEATH Month May Day 19 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1892
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, retired		10b. KIND OF BUSINESS OR INDUSTRY Vet. Adm. Perry Point	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Mahoney		14. MOTHER'S MAIDEN NAME Ella Heath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I		16. SOCIAL SECURITY NO. None	
INFORMANT Newton H. Mahoney, Jr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Generalized Arteriosclerosis DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19 62		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from May 17, 1962 to May 19, 1962 , that I last saw the deceased alive on May 17, 1962 , and that death occurred at 4 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner		ADDRESS (Street, city or town, state) No. 14 East Rd	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.		DATE SIGNED 5/20/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-62	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Elkton (Rural) Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR DATE MAY 23 '62	
ADDRESS North East, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD TIME

1973

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

<div> <div>1</div> <div>05715</div> <div>05710</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 5 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital of Cecil County						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS Circus Trailer Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ellwood Lee McDonald						4. DATE OF DEATH Month Day Year May 28, 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/25		9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry McDonald						14. MOTHER'S MAIDEN NAME Goldie Helmick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes - W.W. II						16. SOCIAL SECURITY NO. 234-32-2239		17. INFORMANT Naoma M. McDonald, X Wife Address 34 S. Lloyd Street Baltimore 2, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion, acute DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. R. C. Dodson						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Dr. R. C. Dodson						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF X 6/1/62		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or country) (State) Rising Sun, Md.	
23. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue #29						24a. REC'D BY REGISTRAR DATE MAY 31 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 16 1962											
MAY 16 1962											
MAY 16 1962											
MAY 16 1962											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05711											
1. PLACE OF DEATH											
a. COUNTY											
Cecil MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
Rural North East											
c. LENGTH OF STAY IN lb											
4 hours											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)											
1221 B. Street											
2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)											
e. STATE											
Delaware											
b. COUNTY											
New Castle											
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
Wilmington											
d. STREET ADDRESS											
1221 B. Street											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)											
First Middle Last											
Charlie N. Miller											
4. DATE OF DEATH											
Month Day Year											
5 12 19 62											
5. SEX											
male											
6. COLOR OR RACE											
Colored											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>											
8. DATE OF BIRTH											
11-18-1906											
9. AGE (In years last birthday)											
55 yrs.											
IF UNDER 1 YEAR											
Months Days Hours Min.											
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)											
Material handler											
10b. KIND OF BUSINESS OR INDUSTRY											
Chrysler Corp											
11. BIRTHPLACE (State or foreign country)											
Kentucky											
12. CITIZEN OF WHAT COUNTRY?											
U.S.A.											
13. FATHER'S NAME											
George Miller											
14. MOTHER'S MAIDEN NAME											
Ernest Lucy Randle											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)											
no											
16. SOCIAL SECURITY NO.											
360-01-9778											
17. INFORMANT											
Mrs Ernest Lucy Dickerson 9403 Burnette St.											
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)											
929.8 DUE TO											
Accidental Drowning											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Fell off trestle into North East River											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
Was fishing on a trestle and line was caught, went to get it off and fell into river											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. 9:10 PM 5 12 19 62											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
North East River North East Cecil Md.											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE											
R. C. Dodson											
EXAMINER'S NAME (Type)											
R. C. Dodson											
22a. BURIAL, CREMATION, REMOVAL (Specify)											
BURIAL											
22b. DATE THEREOF											
May 17 1962 5-17-1962											
22c. NAME OF CEMETERY OR CREMATORY											
Detroit Memorial Park											
22d. LOCATION (City, town, or country) (State)											
Detroit Michigan											
23. FUNERAL DIRECTOR											
Edward R. Bell											
24a. REC'D BY REGISTRAR											
MAY 16 '62											
24b. REGISTRAR'S SIGNATURE											
Arthur S. Evans											

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TO DEPARTMENTAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MAYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
05712													
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City, R.D.1. 2 yrs.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Chesapeake City R.D.1									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert Allen Morris				4. DATE OF DEATH Month 5 Day 26 Year 19 62									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-1958		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days			
										IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Child				11. BIRTHPLACE (State or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Langley Morris				14. MOTHER'S MAIDEN NAME Hattie May Lenard									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs. Robert L. Morris					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.1 Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into pond on farm									
20c. TIME OF INJURY Month, Day, Year 5 26 62				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm					
				20f. (City or town) Chesapeake City R.D.				Cecil Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				Address Rising Sun Cecil Md.				5-27-62					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 30, 1962				22c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery					
				22d. LOCATION (City, town, or country) Hagermarket				Na.					
23. FUNERAL DIRECTOR Piper General Home D.M. See				ADDRESS Elton				24a. REC'D BY REGISTRAR DATE JUN 1 '62					
								24b. REGISTRAR'S SIGNATURE Arthur L. Harris					

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(M)

Cecil

Ms.

Cecil

Chesapeake City, N.D.I. 2 yrs.

Chesapeake City N.D.I.

Robert

Alfon

Morris

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12-14-1958

CHILD

CHILD

Delaware

U.S.A.

Robert Langley Morris

Mattie Mary Hayward

none

Mrs. Robert L. Morris

Itomed

Well into pond on farm

Cecil

Chesapeake City N.D.

Year

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X

R.C. Dabson

Rating and Cecil No.

2-27-62

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
05718												
05713												
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 38 Granite Ave						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 38 Granite Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Paul Murray						4. DATE OF DEATH Month May Day 20 Year 1962						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1900		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist, U.S.N. Training Center						10b. KIND OF BUSINESS OR INDUSTRY Maryland			11. BIRTHPLACE (County & State, or foreign country) U S A			
13. FATHER'S NAME William J. Murray						14. MOTHER'S MAIDEN NAME Mary E. Murray						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 218-03-2927			17. INFORMANT Joseph W. Murray, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial Infarction 420.1 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes 22b. INTERVAL BETWEEN ONSET AND DEATH 3 yrs - 5 yrs												
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Port Deposit, Md.		20g. (County) Cecil		20h. (State) Md.		
21. I certify that (I) (this hospital) attended the deceased from May 19, 1962 to May 19, 1962 , that (I) (we) last saw the deceased alive on May 19, 1962 , and that death occurred at 5 A.M. from the causes and on the date stated above.												
22a. SIGNATURE Clarence I. Benson						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson						22d. ADDRESS Port Deposit, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-1962		23c. NAME OF CEMETERY OR CREMATORY Mt. Erin				23d. LOCATION (City, town or county) Havre De Grace, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson						ADDRESS Perryville, Md.			25a. REC'D BY REGISTRAR DATE MAY 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

(M)

Coast

Port Deposit

33 Granite Ave.

Paul

Maria

William J. Murray

Maryland

Port Deposit

33 Granite Ave.

Murray

June 13, 1960

Assistant, U.S.N. Training Center, Maryland

Harry E. Murray

213-03-2827 Joseph W. Murray, Port Deposit, Md.

Period 5-22-1961 Mr. Martin

Operator J. Benson

Port Deposit, Md.

Have De Grace, Md.

05719

05714

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Nursing Home		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Raymond W. Nickerson		4. DATE OF DEATH Month May Day 23 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January, 5, 1902
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Broom Salesman	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter V. Nickerson		14. MOTHER'S MAIDEN NAME Annie E. Garey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-34-2127	
INFORMANT George Humphry,		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hours 5 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/15, 1961 to 5/23, 1962 that I last saw the deceased alive on 5/22, 1962 , and that death occurred at 2 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 5/23/62 ACTUAL SIGNATURE Neil R Taylor M.D. PHYSICIAN'S NAME (Type) Neil R Taylor From Rising Sun, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May, 26, 1962	
22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Hellington, Md.		24a. REC'D BY REGISTRAR DATE MAY 28 62	
24b. REGISTRAR'S SIGNATURE Arthur S. Hance			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0314

CONFIDENTIAL

0314

CONFIDENTIAL

MEMORANDUM FOR THE DIRECTOR, FBI
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The remainder of the memorandum body is illegible due to extreme fading.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05720 CERTIFICATE OF DEATH 05715											
Items #13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100											
1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. District of Columbia							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 32				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital				d. STREET ADDRESS 1458 Columbia Rd, N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN				First Middle Last E. QUISENBERRY				4. DATE OF DEATH May 14 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 11, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 9 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Office				11. BIRTHPLACE (County & State, or foreign country) Lexington, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John E. Quisenberry				14. MOTHER'S MAIDEN NAME Katie B. Barley				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes WW I			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT VA Hospital Record, Perry Point, Md.				Address Parrish			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis, generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (this hospital) attended the deceased from April 13, 1962 to May 14, 1962 and that death occurred at 12:40 PM from the causes and on the date stated above.											
22a. SIGNATURE A. L. MOONEY, M.D. Asst. Pathologist											
22b. DATE SIGNED May 15, 1962											
22c. PHYSICIAN'S NAME (Type) VA Hospital, Perry Point, Md.											
22d. ADDRESS											
23a. BURIAL, CREMATION, or other disposition of body Removal											
23b. DATE THEREOF May 15, 1962											
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery											
23d. LOCATION (City, town or county) (State) Prince George County, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE H. S. HINES FUNERAL HOME											
ADDRESS Washington, D.C.											
25a. REC'D BY REGISTRAR MAY 17 '62											
25b. REGISTRAR'S SIGNATURE Arthur L. Kline											

03720

(M)

Local

Perry Point

VA Hospital

Director of Colonization

Washington

1922 Columbia Rd., N.W.

E. LUISBERRY

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John

Wife

Miss

X

Aug 11, 1924

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U.S.

Lexington, Va.

Office

Chief

John A. LUISBERRY

Lucile E. Bailey

Unknown VA Hospital Record, Perry Point, Md.

Myocardial Infarction

Atherosclerosis Heart Disease

Atherosclerosis, Generalized

VA

April 13, 62

12:10 PM

A. J. KOSNY, M.D., Asst. Pathologist

VA Hospital, Perry Point, Md.

May 17, 1962 Lt. Lincoln Cemetery

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. _____ may be retained by the hospital or attending physician. Page _____ should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05721 CERTIFICATE OF DEATH 05716

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City c. LENGTH OF STAY IN 1b 91 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bohemia nr 2nd		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City d. STREET ADDRESS Bohemia nr 2nd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RALPH H. REES		4. DATE OF DEATH Month Day Year May 31 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1871
9. AGE (In years last birthday) 91 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardware and Grain Merchant	11. BIRTHPLACE (County & State, or foreign country) Chesapeake City Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas A. Rees	
14. MOTHER'S MAIDEN NAME Georgianna Griffin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Elizabeth W. Rees Chesapeake City, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC NEPHRITIS DUE TO 15 years (c) HYPERTENSION INTERVAL BETWEEN ONSET AND DEATH 5 days 24 YEARS 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE 10, 1932 to MAY 31, 1962 , that (I) (we) last saw the deceased alive on MAY 30, 1962 , and that death occurred at 4:10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Henry U. Davis M.D.		22b. DATE SIGNED 5/31/62	
22c. PHYSICIAN'S NAME (Type) HENRY U. DAVIS M.D.		22d. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-2-1962	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City, town or county) (State) Chesapeake City, Cecil Co., MD
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS Joseph R. Grant North East, Maryland		25a. REC'D BY REGISTRAR JUN 5 1962 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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...and the ...

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5095-5096 Infant

Wm. H. R. Co., New York City

TO HOSPITAL CLERK: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
05723 CERTIFICATE OF DEATH 05718																			
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Atlantic City														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlantic City														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 33 S. Caroline Avenue														
3. NAME OF DECEASED (Type or print) First OTTILIE Middle (NMI) Last SCHERER					4. DATE OF DEATH Month May Day 22 Year 19 62														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-12-67		9. AGE (In years last birthday) 95 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
13. FATHER'S NAME Henry W. Scherer					14. MOTHER'S MAIDEN NAME Sarah E. Wortz														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes S.A.W. None					16. SOCIAL SECURITY NO. None					17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3-5 days										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 p.m.									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that XXXXXX attended the deceased from May 14 to May 22 , 19 62 and that death occurred at 8:45 a.m. M, from the causes and on the date stated above.										22a. SIGNATURE A. L. Mooney M.D.					22b. DATE SIGNED 5-22-62				
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.										22d. ADDRESS									
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/> (Specify)					23b. DATE THEREOF 5/23/62					23c. NAME OF CEMETERY OR CREMATORY Arlington									
23d. LOCATION (City, town or county) (State) Drexel Hill, Pa.					24. FUNERAL DIRECTOR'S SIGNATURE Bannington & Son, Havre de Grace, Md.					24b. REC'D BY REGISTRAR DATE MAY 28 '62									
24a. REGISTRAR'S SIGNATURE William S. Kraus																			

Geoff

Larry Point, Md.

5 yrs. 8 days

Atlantic City

New Jersey

Veterans Administration Hospital

33 S. Caroline Avenue

OTOLIC (ENT)

ROCHAM

May

22

64

Female

White

1-12-87

93

Registered Nurse

Private

Philadelphia, Pa.

USA

Henry W. Bohrer

Barth E. Gertz

None

2.1.1.1.

Yes

Hospital Records, VAM, Larry Point, Md.

Phonograph records, unrecorded

arteriosclerotic heart disease

VA

Nov 14

27

Nov 22

62XXXXXX

XXXXXXXXXXXXXXXXXXXX

1947-48.

A. I. MOORE, Asst. Clinical Pathologist, VAM, Larry Point, Md.

Brook Hill, Pa.

Arlington

Remington, Pa., Harry de Grace, Md.

Page 4 of 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05724

05719

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 72 East Main St.	
3. NAME OF DECEASED (Type or print) First Frank Middle Slack Last Slack		4. DATE OF DEATH Month May Day 14 , Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1892
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad employee		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Enos Slack		14. MOTHER'S MAIDEN NAME Ella M. Eastburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Marian Glenn		Address Newark, Del. 72 E. Main St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Infarction of the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary occlusion DUE TO (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13 , 19 62 to 5-14 , 19 62 , that I last saw the deceased alive on 5-14-62 , 19 62 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Williford Eppes M.D.		ADDRESS (Street, city or town, state) 327 East Main St. Newark, Delaware	
DATE SIGNED 5/16/62			
PHYSICIAN'S NAME (Type) Williford Eppes			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1962	
22c. NAME OF CEMETERY OR CREMATORY Welsh Tract Cem.		22d. LOCATION (City, town, or county) (State) Newark, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE R.T. Jones		ADDRESS Newark, Del.	
24a. REC'D BY REGISTRAR DATE MAY 18 '62		24b. REGISTRAR'S SIGNATURE Calvin S. Thomas	

CERTIFICATE OF DEATH

DATE OF BIRTH		PLACE OF BIRTH	
1900		Boston	
SEX		M	
MARRIED		Single	
OCCUPATION		Student	
EDUCATION		High School	
RELIGION		Roman Catholic	
RACE		White	
COLOR		Fair	
HAIR		Brown	
EYES		Blue	
SKIN		Fair	
TALL		5' 10"	
WEIGHT		150 lbs	
TEMPERATURE		98.6	
PULSE		72	
BLOOD PRESSURE		120/80	
DIAGNOSIS		Tuberculosis	
TREATMENT		None	
PROGNOSES		Fatal	
CAUSE OF DEATH		Tuberculosis	
MANNER OF DEATH		Natural	
PLACE OF DEATH		Home	
DATE OF DEATH		May 10, 1900	
TIME OF DEATH		10:00 AM	
SIGNATURE OF PHYSICIAN		J. J. [illegible]	
SIGNATURE OF WITNESS		[illegible]	
SIGNATURE OF DEATH REGISTRAR		[illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05725

CERTIFICATE OF DEATH

05720

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 52 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 116 W. High St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Marion Middle W. Last Slonecker, Sr.				4. DATE OF DEATH Month May Day 25 Year 19 62											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1887 74 yrs.		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 2 Days 1		IF UNDER 24 HRS. Hours 1 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. BUSINESS OR INDUSTRY Post Office				11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Adam Slonecker						14. MOTHER'S MAIDEN NAME Julia Brauchler									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----				17. INFORMANT Mrs. Marion W. Slonecker, Sr.				Address 116 W. High St. Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage with hemiplegia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic cardiovascular diseases DUE TO (c) unknown												INTERVAL BETWEEN ONSET AND DEATH 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year May 25 19 62 Hour a.m. 11:15p p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Elkton		(County) Maryland		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from May 25 19 62 to May 25 19 62 that (I) (we) last saw the deceased alive on May 25 19 62, and that death occurred at 1:15p from the causes and on the date stated above.															
22a. SIGNATURE St. Ralph Andrews, Jr.				22b. ADDRESS 233 E. Main Street Elkton, Maryland		22c. PHYSICIAN'S NAME (Type) St. Ralph Andrews, Jr., M.D.		22d. DATE SIGNED 5/ 2 6/62							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/28/62		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery				23d. LOCATION (City, town or county) Elkton, Md. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				24b. ADDRESS Elkton, Md.		25a. REC'D BY REGISTRAR JUN 5 '62				25b. REGISTRAR'S SIGNATURE Arthur S. House					

M

03728

Coall

Elkton

Union Hospital

Union

White

Clerk

Aden Stonacker

Julia French

116 W. High St.

Mrs. Aden W. Stonacker, Sr. Elkton, Md.

12 months

Out for 1 month with cardiac

cardiovascular disease

x

W. C. Co. 03 03 03

1170

03

03 03

x

333 E. Main Street, Elkton, Maryland

Elkton Cemetery, Elkton, Md.

Elkton, Md.

Elkton Cemetery, Elkton, Md.

Elkton, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05726										
05721										
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Rural</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>					d. STREET ADDRESS <u>R. D. #1</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER NICKOLAS VESPER</u>					4. DATE OF DEATH Month Day Year <u>May 26, 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Nickolas Vesper</u>					14. MOTHER'S MAIDEN NAME <u>No Information</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mrs. Josephine Dandoe, Elkton, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic Calculus cholecystitis</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>15 April, 1962</u> to <u>26 May, 1962</u> , that (I) (we) last saw the deceased alive on <u>26 May, 1962</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Klaus H. Huebner M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/26/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>					22d. ADDRESS <u>No. 4 E. 1st St</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-1-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ELKTON, MARYLAND</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME DONALD R. Du</u>					ADDRESS <u>ELKTON Md</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY FOR
FOREIGN AFFAIRS
MAIL ROOM
WASHINGTON, D.C. 20250
FROM: [illegible]
TO: [illegible]
SUBJECT: [illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Md. b. COUNTY Carroll					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Conowingo Rural						c. LENGTH OF STAY IN 1b Visiting					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) West-Minister					
						d. STREET ADDRESS 328 E. Main St.					
3. NAME OF DECEASED (Type or print) Charles Windsor Watson						4. DATE OF DEATH Month 5-6 Day 62 Year 19					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-1933		9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Shoe Company		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME David D. Watson						14. MOTHER'S MAIDEN NAME Ida Horning					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 215-32-3383					
17. INFORMANT Mrs. Charles W. Wm Watson						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning											
850X DUE TO											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat overturned and threw him in water					
20c. TIME OF INJURY Month, Day, Year 5 a.m. 5-6-62 p.m.						20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River					
20e. (City or town) West-Minister						20f. (County) Carroll					
20g. (State) Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. C. Dodson						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R. C. Dodson						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED 5-10-62					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 5/12/62					
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery						22d. LOCATION (City, town, or country) (State) Westminster, Md.					
23. FUNERAL DIRECTOR J. E. Smyer, Jr., Westminster, Md.						24a. REC'D BY REGISTRAR MAY 14 '62					
						24b. REGISTRAR'S SIGNATURE Arthur S. Hume					

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07787



Conowingo, Md.
Local

Station

Westminster

Control

320 E. Main St.

x

Charles

Winton

Watson

5-6-32

x

12-20-1932

28

Sanitor

Shoe Company

Id.

W.S.A.

David D. Watson

The Morning

215-32-3283 Mrs. Charles E. Wm. Watson

no

Thomson

x

5-6-32

x

Swadlowham River

lost overturned and threw him in Swadlowham River

x

W. G. Lison

Livingston, Md.

x

5-1-32

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05728

05724

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 126 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Freeland	
3. NAME OF DECEASED (Type or print) First Alfred Middle Whipperman Last		d. STREET ADDRESS RD # 1	
4. DATE OF DEATH Month May 5, Day 1962		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 23 92
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 1 Days 12 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Chestnut Ridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hamilton Whipperman		14. MOTHER'S MAIDEN NAME Rose Warred	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 178 24 9407	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia of Brain (CVA) 420.0 DUE TO Emboli from mural thrombus, left atrium. Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease and (c) stating the underlying cause last. Hypertensive Cardio-vascular disease.		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Dec 30, 1961 to 5-5, 1962, that (he) saw the deceased alive on 12-30-61 and that death occurred at 5:35 PM, from the causes and on the date stated above.			
22a. SIGNATURE A. L. MOONEY		22b. DATE SIGNED 5-6-62	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, MD.		22d. ADDRESS VAH., Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1962	
23c. NAME OF CEMETERY OR CREMATORY Middleton Cemetery		23d. LOCATION (City, town or county) (State) Freeland, Md. (Baltimore Co.)	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Hartman, New Freedom, Pa.		25a. REC'D BY REGISTRAR DATE MAY 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



1178

1178

CERTIFICATE OF DEATH

U-11

Protestant

128 days

Army Point

At home

No. 1

Alison

Int. person

May 2

Male

White

2 22 22

VO

1 12

Marriage

On ship bridge, No.

U.S.A.

1 day 22 22 22

Post-mortem

No. 1

128 days

At home - Army Point, No.

Neurological of brain (CVA)

8 days

Infant from neural tube, left side.

8 days

Systemic cardiac-vascular disease.

Yes

Infant, 128 days

1-2

128 days

11

1-2-0-02

V.L., Army Point, No. 128

M. ROBERT, No. 128

128 days

128 days

128 days

128 days

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

<div> <div> <div>1</div> <div>05729</div> </div> <div> <div>3</div> <div>05725</div> </div> </div> <div> <div> <div>1</div> <div>05729</div> </div> <div> <div>3</div> <div>05725</div> </div> </div>													
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Nottingham Road d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Rural Elkton)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Nottingham Road Rural Elkton d. STREET ADDRESS Nottingham Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle F Last Wilmer						4. DATE OF DEATH Month 5 Day 1 Year 19 62							
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH March 23 1888 9. AGE (In years last birthday) 74 yrs. 7470 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY All kind 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Wilmer 14. MOTHER'S MAIDEN NAME no information Anna Hillman						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 218-14-8246 17. INFORMANT William J. Wilmer, Elkton, Maryland and Hospital Records Elkton, Md.							
18. CAUSE OF DEATH [Enter only on cause of death line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malnutrition and Heart Block. 286.5 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 286.5 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 15 min.													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE R.C. Dodson EXAMINER'S NAME (Type) R.C. Dodson						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City, town, or county) Rising Sun Md. DATE SIGNED 5-2-62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-4-62		22c. NAME OF CEMETERY OR CREMATORY Union Methodist				22d. LOCATION (City, town, or country) Elkton R.D., Cecil Co., Md.			
23. FUNERAL DIRECTOR Joseph R. Grant Address North East, Maryland						24a. REC'D BY REGISTRAR DATE MAY 7 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

MEDICAL CERTIFICATION

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Page 4
The low requires that the death certificate be executed within 72 hours after death.
TO HOSPITAL OR ATENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAY 24 '62
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05726

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wilson Ave.			d. STREET ADDRESS Wilson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Florence Middle Elizabeth Last Yocum			4. DATE OF DEATH Month 5/ Day 22/ Year 1962		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1887	9. AGE (In years lost birthday) yrs. 75	10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nursing		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Yocum			14. MOTHER'S MAIDEN NAME Elizabeth Stephens		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-3407		17. INFORMANT Mrs. Edwin H. Nickols	
				Address 9m Broadway West Chester Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 3 months INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 months					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/30 19 62 to 5/22 19 62 that (I) (we) last saw the deceased alive on 5/22 19 62 and that death occurred at 5/22 M, from the causes and on the date stated above.					
22a. SIGNATURE Neil Taylor		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/22/62	
22c. PHYSICIAN'S NAME (Type) Neil Taylor Jr		22d. ADDRESS Rising Sun, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/1962		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cem.	
23d. LOCATION (City, town, or county) Cherry Hill		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. McFullen		ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR DATE MAY 24 '62	
				25b. REGISTRAR'S SIGNATURE Charles S. Kline	

05130

Carl

State

Wilson Ave.

Flora

Female

Practical nursing

Samuel Young

No

100
100

100

Barry Hill Co. Cherry Hill

State Sun, No.

05130

Carl

State

Wilson Ave.

Flora

Female

Practical nursing

Samuel Young

No